27 Majd M, Rushton HG. Renal cortical scintigraphy in the diagnosis of acute pyelonephritis. *Semin Nucl Med* 1992;**22**: 98–111.
28 Rushton HG, Majd M, Jantausch B, *et al*. Renal scarring following reflux and nonreflux pyelonephritis in children: evaluation with 99m-technetium-dimercaptosuccinic acid scintigraphy [published erratum appears in *J Urol* 1992; **148**:898]. *J Urol* 1992;**147**:1327–32.
29 Fleisher GR, Rosenberg N, Vinci R, *et al*. Intramuscular versus oral antibiotic therapy for the prevention of meningitis and other bacterial sequelae in young, febrile children at risk for occult bacteremia. *J Pediatr* 1994;**124**:504–12.
30 Pohl HG, Rushton HG, Park JS, *et al*. Adjunctive oral corticosteroids reduce renal scarring: the piglet model of reflux and acute experimental pyelonephritis. *J Urol* 1999; **162**:815–20.

TRANSATLANTIC TOPIC

Shared decision making in pediatrics

Both in Great Britain and the United States, shared decision making is a relatively new concept in medicine.[1 2] The term describes a partnership between health care providers and patients, in which each contributes equally to decisions about different aspects of treatment. The importance of shared decision making varies, depending upon the amount of discretion that exists in a particular decision. The concept has been explored extensively in adult medicine, focusing on surgical procedures and other medical decisions associated with significant morbidity—such as mammography as an appropriate screen for breast cancer. In the US, the goal has been to produce decision aids, such as videos, that give patients information presented in a neutral fashion about risks and benefits of different options.[3] For example, it remains unclear if screening adult males for prostatic carcinoma is worthwhile. Videos have been produced that describe the pros and cons of screening, diagnosis, and treatment.

Shared decision making should not be confused with the informed choice model of communication, "in which control over decision making is vested entirely in the patient", and the physician withdraws from the process.[3] It is obviously quite different from older more traditional paternalistic style of decision making. Whether shared decision making is fundamentally different from family centred care is less clear, although family centred care often focuses on children with chronic medical conditions, inpatient issues and comprehensive services, rather than individual medical decisions.

How does shared decision making affect child health? In some regards, as many of the decisions we make in the ambulatory environment lack clear evidence of benefit, and uncertainty is common, shared decision making is an important aspect of paediatric care. For example, the question of treating children with acute otitis media with antibiotics is one in which shared decision making could play a vital role. Approximately 80% of patients recover from acute otitis media without antibiotics. Few go on to have serious complications. Can this information be presented in a neutral fashion so parents can participate as shared decision makers? I have often been asked by parents with children who have Attention Deficit Hyperactivity Disorder about the role of alternative medicine in their treatment. I inform parents that there are no definitive data demonstrating harm or benefit,[4] and since the placebo effect is quite powerful, I support parents if they decide to use an alternative medicine approach. Other examples of common problems in paediatrics in which shared decision making should play an important role include: appropriate radiographic evaluation of children with urinary tract infections, immunisations for varicella and perhaps hepatitis B and pneumococcal disease, circumcision, asthma treatment, and various approaches to behavioural and developmental problems.

It is not possible to produce decision aids for the myriad choices we face in paediatrics that should involve shared decision making. Unfortunately, it is time consuming and takes a great deal of knowledge to present information in a neutral unbiased manner. Many of us neither have the skills nor the time to do this. However, as our patients become better informed about their options, shared decision making will become a necessary part of medicine. Recently, Towle and Godolphin[5] described eight principles that physicians need to adopt in order to practice shared decision making:

- Develop a partnership with the patient
- Review the patient's preference for information
- Review the patient's preference for role in decision making
- Ascertain and respond to patient's ideas, concerns, and expectations
- Identify choices and evaluate evidence from research
- Present evidence
- Make or negotiate a decision
- Agree on an action plan.

How well these principles will work in paediatrics, with parents who serve as surrogates for the real patients, is unknown. However, I suspect that most are applicable to the parent-physician encounter. As few of us have received any formal training about shared decision making, we must once again educate ourselves about a new and exciting development in medicine.

H BAUCHNER
US Editor

1 Elwyn GJ, Edwards A, Kinnersley P. Shared decision making in primary care: the neglected second half of the consultation. *Br J Gen Pract* 1999;**49**:477–82.
2 Coulter A. Partnerships with patients: the pros and cons of shared clinical decision-making. *J Health Serv Res Policy* 1997;**2**:112–21.
3 Edwards A, Elwyn G. The potential benefits of decision aids in clinical medicine. *JAMA* 1999;**282**:779–80.
4 Chan E, Gardiner P, Kemper KJ. "At least it's natural...." Herbs and dietary supplements in ADHD. *Contemporary Pediatrics* 2000;**17**:116–35.
5 Towle A, Godolphin W. Framework for teaching and learning informed shared decision making. *BMJ* 1999;**319**:766–71.